

**Orange Grove
Junior High School
2018 – 2019**

**Cheerleader/Mascot
Packet**

Check the position for which you are trying out:

_____ Cheerleader

_____ Mascot

Checklist

- *Please use this checklist to check off all forms that have been properly filled out.*
- **REMEMBER:** *Any packet that is incomplete will not be accepted and will therefore result in the candidate being disqualified for tryouts.*
- *Place all forms listed below behind this page and in the order in which they are listed.*

_____ Cheer/Mascot Application

_____ Parent Permission Form

_____ Student Agreement

_____ Proof of Insurance Requirement (including copies of both sides of insurance card)

_____ Physical Verification Form (signed by the Athletic Trainer)

_____ Complete Physical (if applicable)

_____ Eligibility Form (completed by your teachers)

Please return the checklist and completed required documents to the Orange Grove Junior High Office by 3:45 PM on Friday, February 16, 2018.

Keep the Cheerleading/Mascot Constitution for your records.

Cheerleader/Mascot Application

Check the position for which you are trying out:

_____ Cheerleader

_____ Mascot

Name: _____

Date of Birth: _____

Address: _____ City: _____

Phone: _____

Parent(s)/Guardian(s): _____ Phone: _____

_____ Phone: _____

Please check your current academic year:

_____ 6th Grade

_____ 7th Grade

With my signature, I certify that all information given in this application is complete and accurate. I also understand that any discrepancies will result in my disqualification from the tryout process or removal from the squad.

Applicant Signature

Date

Parent Signature

Date

Parent Permission Form

_____ (candidate name) has indicated his/her desire to become a cheerleader or mascot at Orange Grove Junior High. If he/she is selected, there are certain rules, requirements, responsibilities and obligations for which he/she will be held accountable in order to remain a member of the cheer team.

I agree with the rules, requirements, responsibilities, and obligations set forth in the Cheerleading/Mascot Constitution and will assist in every way to see that these are enforced.

If my son/daughter is selected, I will see that he/she attends all scheduled cheerleading events and is picked up from these events at the announced time(s).

I have read all forms and paperwork, including the financial obligations listed on the parent letter and I agree with the rules, requirements, responsibilities and obligations.

I hereby give _____ (candidate name) permission to tryout to become a member of the Orange Grove Junior High Cheerleading Squad. I will not hold the school or coach responsible for any injury occurring during tryouts and/or the cheerleading year.

Parent Signature

Date

Student Agreement Form

I, _____, have read and understand the responsibilities outlined in the 2017-2018 OGJH Cheerleader/Mascot Constitution. I understand that I will be held accountable for the behavior and consequences outlined in the Cheerleader/Mascot Constitution at school, school-sponsored activities, and school-related activities including travel time. I promise to uphold these high standards in a manner that will always be a credit to Orange Grove Junior High.

Student Signature

Date

Proof of Insurance Requirement

I understand that one requirement of eligibility for cheerleader participation is to show proof of primary insurance coverage when applicable.

Check one option only.

_____ I verify that my son/daughter is covered by my own insurance policy or other medical coverage. I understand that this insurance or medical coverage will serve as the primary insurance coverage for my child. I further understand that my child is also covered by a school insurance that provides coverage for all students who represent the school district in any extracurricular activity. Given that my child is covered by a primary insurance, I understand that this supplemental school insurance will serve as a secondary insurance to my primary insurance. I have attached a copy of both sides of my insurance card or proof of other medical coverage.

_____ I verify that my son/daughter is not covered by any insurance policy or other medical coverage. I understand that my child's only medical coverage is the insurance coverage provided by the school district to all students who represent the school district in any extracurricular activity.

If my child has primary insurance coverage, I authorize school-related personnel to provide insurance information to medical personnel for the purpose of providing medical services for my child.

Parent Signature

Date

Physical Verification Form

****Check either Item 1 or Item 2.**

1. _____ I am currently involved in school athletics and therefore have had the Orange Grove High School Athletic Trainer verify that my physical is indeed on file in the Orange Grove Athletic Office. Please see the Athletic Trainer's verification statement below.

I verify that _____ (name of candidate) has a current physical on file in the Orange Grove Athletic Office that will serve as a valid physical for the 2017-2018 school year.

Trainer Signature

Date

2. _____ I am not currently involved in school athletics and have therefore attached to this document a completed official UIL physical form.

Eligibility Form

**** Please have each of your teachers complete and sign this form.**

Period	Subject	First Semester Average	Cumulative Average	Comments	Signature
1					
2					
3					
4					
5					
7					
8					

Additional Comments:

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed *annually* by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____
 In case of emergency, contact:
 Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weight more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			18. Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____			<i>Females Only</i>		
How severe was each one? (Explain below)			19. When was your first menstrual period? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Males Only</i>		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	20. Do you have two testicles? _____		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you have any testicular swelling or masses? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

****EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):**

It is understood that even though protective equipment is worn by the athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. **THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ / _____ (____ / ____ / ____)
brachial blood pressure while sitting

Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It *must* be completed if there are yes answers to specific questions on the student's **MEDICAL HISTORY FORM** on the reverse side. * *Local district policy may require an annual physical exam.*

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

Cleared
 Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____
 Address: _____
 Phone Number: _____
 Signature: _____

Must be completed before a student participates in any practice before diving...